The Advisory Board Company

Consulting and Management

# Regional Care Coordination Models

Colorado, North Carolina, Minnesota

West Virginia SIM Better Value Workgroup
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# Key Design Elements of Regional Care Models

**Breadth of Vision-** extent to which the state's vision addresses full range of health determinants

**Payment Reform-** (1) which payers are included? (2) is there a plan to transition to regional global budgets? (3) are there "glide paths" for transitioning providers to performance-based payment?

**Local Leadership Structure-** how are geographic boundaries drawn or communities defined?(state designated or locally self-organized); one backbone organization or multiple?

**State Accountability Programs-** Performance measurement and public reporting

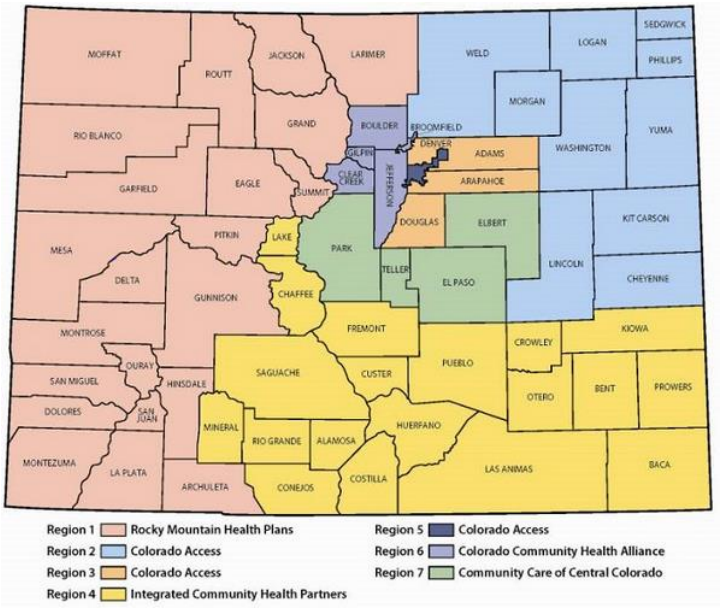
**Delivery System Integration-** what building blocks are used to integrate/coordinate services: primary care, community health workers, social services, hospitals, comprehensive health systems, single regional coordinating entity

**Enhanced Funding for Non-Healthcare Determinants-** examples: assessment of insurance; investment of a portion of "shared savings"; nonprofits' Community Benefit funds; realignment of resources at the state level to non-health sector programs

# Colorado's Accountable Care Collaborative (ACC)

## Regional Care Collaborative Organizations (RCCOs)

- Pilot launched by Colorado's Medicaid program in 2011, serving a subset of Medicaid enrollees, based upon a PCMH approach to primary care
- As of June 2014, 609,051 Coloradans (58% of Medicaid enrollees) were enrolled in the ACC
- State divided into 7 RCCOs and each ACC enrollee is connected with a primary care medical provider (PCMP)
- RCCO and PCMP receive PMPM payments to help them implement care coordination infrastructure
- RCCOs have built a formal network of contracted PCMPs and informal (non-contracted) network of specialists – collaborate with specialists through Medical Neighborhood Model



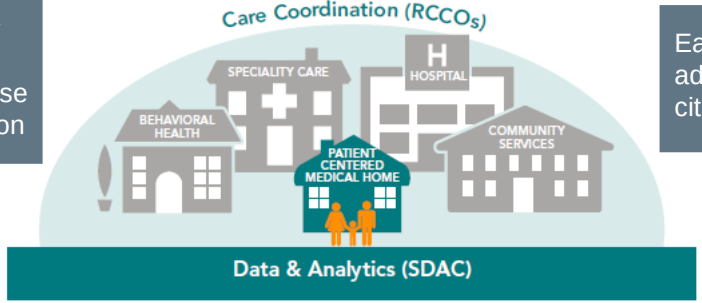



Source: Colorado's State Health Innovation Plan December 2013.

# RCCO Core Components

| Regional Care Collaborative Organizations (RCCO) | Primary Care Medical Providers (PCMP) | Statewide Data and Analytics Contractor (SDAC) |
|---|---|---|
| Seven organizations throughout the state that develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization and outcomes for their population of members. | Primary care providers contracted with a RCCO to serve as medical homes for ACC members. | A health information technology contractor that analyzes and reports on claims data to help the Department, RCCOs and PCMPs see patterns in how members are using health care services. |

Primary Sponsors vary by region – Health Plans and Provider Groups vs. Diverse Stakeholder Representation




Each RCCO has an advisory committee with citizen representation

Source: "Creating a Culture of Change" Accountable Care Collaborative 2014 Annual Report; ; Corrigan, Janet and Elliott S. Fisher. "Accountable Health Communities: Insights from State Health Reform" The Dartmouth Institute for Health Policy & Clinical Practice."

# Colorado's RCCOs – Payment Reform

## FFS and PMPM Payments but May Transition to Global Budgets in Future

**Medicaid Per-Member-Per-Month Payment**

Each RCCO receives a PMPM payment from Medicaid to support care coordination, network development and practice supports for PCMH.

**Key Performance Indicators (KPI)**

RCCOs and PCMPs receive payments for achieving KPI targets, such as ED visits, readmissions, well-child visits, high-cost imaging services.

**Enhanced Medical Home Standards**

Money set aside from PMPM payments to create incentive pool for PCMPs that meet five of the nine high standards for an enhanced PCMH.

**More Members with a Medical Home**

RCCOs will receive a full PMPM only for members who are attributed to a medical home within 6 months of enrolling in the ACC.

Source: "Creating a Culture of Change" Accountable Care Collaborative 2014 Annual Report;

# North Carolina – Community Care of North Carolina

## Overview

- Public-private partnership that provides key components of a medical home and care management for more than 1 million Medicaid enrollees
- Began in 1998 with 9 one-county demonstrations and has grown to include 14 community-based networks that are organized and operated by community physicians, hospitals, health departments and departments of social services
- More than 1,300 primary care practices and about 4,000 physicians
- Saved nearly $1.5 billion in 2007, 2008 and 2009 alone
- 3-to-1 return to state on CCNC's costs – Aug 2015


Source: CCNC March 2013

Source: www.communitycarenc.org ; McCarthy, Douglas and Kimberly Mueller. "Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnership" The Common Wealth Fund June 2009.

# CCNC Development and Support

## Network Development

- Each network is headed by a steering committee that include representatives from medical homes (PCPs), community hospitals, county health departments, and county departments of social services in addition to region-specific providers and organizations
- Each network must serve at least 30,000 which ensured that small counties would have to ban together with neighboring counties
- All networks include:
  - Steering committee
  - Medical management committee
  - Network administrator
  - Medical director
  - Care managers
  - Pharmacist
  - Psychiatrist
  - Special project staff members with specialized skills to support specific local network initiatives

## Program Office

- CCNC began with the program managed by agencies of the state
- Became an independent office in 2006 when elected to participate in a Medicare Health Care Quality Demonstration – allowed Community Care to become a delivery system for all patients, beyond Medicaid; However, unable to maintain the same level of alignment with the State with this model
- Hybrid program office – DHHS responsible for financing, Medicaid policy, contracts, compliance and reporting to state officials; CCNC responsible for training, information services, technical program management and communications



Source: CCNC Toolkit Modules 4 and 5

# Example Initiatives of CCNC

## Information Continuity

- Care managers in regional networks use a common Web-based case management platform to track patients and their assessments, facilitate care planning, and engage in secure messaging.

## Care Coordination and Transitions

- Develops and disseminates resources and tools to support population health management for Medicaid patients.
- Local networks hire nurse case managers who work in concert with physicians to identify high-risk patients, assist in patient education and follow up, coordinate care, and help patients access services.

## Peer Review and Teamwork for High-Value Care

- Network clinical directors identify best practice models and create system wide quality measures and initiatives; local networks implement initiatives locally.
- Physicians receive comparative performance profiles compiled by the central program office to motivate improvement on network initiatives.

## Improved Access to Appropriate Care

- Each CCNC patient selects or is assigned to a PCP who serves as a medical home, that works to increase after-hours and weekend availability
- Mental health integration pilot co-locates behavioral health specialists in primary care
- Local networks partner with local safety-net providers to create integrated networks of care for the uninsured.

Source: McCarthy, Douglas and Kimberly Mueller. "Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnership" The Common Wealth Fund June 2009.

# Minnesota's Accountable Communities for Health (ACH)

- Through a competitive process, state awards $7M to up to 15 ACHs, defined as integrated networks of providers and community organizations moving toward accountability for improved population health
- Build on three building blocks: Over 300 certified Health Care Homes, 3 State-funded Community Care Teams, and 4 ACOs
- Must include an ACO or ACO-like arrangement; demonstrate progress towards a total cost of care payment model including shared savings/risk with community partners; and designate a leadership committee with the majority composed of citizens and non healthcare providers
- Required to be all-payer, on a glide path to performance-based payment
- Statewide Quality Reporting and Measurement System to support performance measurement and transparency, including patient satisfaction, quality and costs.

**Phase 1**

- Fully implement and prepare for testing nine ACO contracts under the Medicaid HCDS demonstration, in alignment with other payers and the State's ACO early innovators.

**Phase 2**

- Award a second round of ACOs under the Medicaid HCDS in conjunction with other payers, and provide infrastructure support for measurement, quality improvement, data exchange and practice transformation.
- Expansion of services ACOs are accountable for, including mental health and long-term supports and services

**Phase 3**

- Continue testing of current ACOs, continue infrastructure support for integrated services in ACOs and expand Accountable Communities for Health.
- Expansion from three existing Community Care Teams to up to 15 Accountable Communities for Health through RFP process.

Source: Minnesota State Health Innovation Plan Project Narrative; Corrigan, Janet and Elliott S. Fisher. "Accountable Health Communities: Insights from State Health Reform" The Dartmouth Institute for Health Policy & Clinical Practice."